The HealthGuard PPO Plan

Summary of Benefits for the Employees and Retirees of the State of Vermont

What Does "PPO" Mean?

- The term "PPO" describes a "Preferred Provider Organization" plan. The "HealthGuard PPO Plan" is a plan that is based on a national network of health care providers who have contracts with our Plan Administrator.

It's Your Choice

- You get access to quality care at the lowest out-of-pocket costs available under your plan by seeing network providers. You are not required to coordinate care through a Primary Care Physician. You also get the **freedom to choose** providers who aren't part of the network. Your benefits are the highest when you see "preferred providers", but you're still covered for visits to non-network providers at a higher cost share.

Important Medical Plan Features

- **Preventive care services** for you and your children are described in the Benefits Highlights and paid at 100%.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**.

Drug Plan

- The program is administered by Express Scripts, Inc. The annual deductible is $25 per covered person per year. The new plan covers 90% of the cost of generic drugs, 80% of the cost of preferred brand drugs and 60% of the cost for non-preferred brand drugs. For the 2014 Plan Year, the maximum out-of-pocket cost per individual per year is $775 (which includes the deductible). **40% copay drugs do not contribute to the maximum out of pocket limit.** At the local pharmacy, you show you drug plan card and pay your copay; the State is automatically billed for the balance of the cost. The drug plan also features a mail order option, with the convenience of direct home delivery for long-term maintenance drugs.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
	THIS TABLE SHOWS HOW MEDICALLY NECESSARY SERVICES ARE COVERED AFTER YOU HAVE MET YOUR ANNUAL MEDICAL DEDUCTIBLE.	**THIS TABLE SHOWS HOW MEDICALLY NECESSARY SERVICES ARE COVERED AFTER YOU HAVE MET YOUR ANNUAL MEDICAL DEDUCTIBLE.**
Doctor Office Visits such as:		
Preventive Care/Well Care:	100%	60%
Periodic Physical Exams (Children and Adults)	100%	60%
Routine Immunizations and Injections	80%	60%
Adult/Child Medical Care for Illness or Injury	80%	60%
Procedures performed in a Physician's Office		
Routine Mammograms	100%	100%
Specialist Office Visits such as:		
Office Visits-Consultations and Physician Services	80%	60%
Well Care (Includes Pap Test and PSAs)	100%	60%
Procedures Performed in Physician's office	80%	60%
Inpatient Hospital Services including:		
Semi-Private Room and Board	80%	60%
Physician Services		
Diagnostic/Therapeutic Lab and X-ray	***All inpatient hospital admissions required Precertification. Call the toll free number on your ID Card.***	***All inpatient hospital admissions required Precertification. Call the toll free number on your ID Card.***
Drugs and Medication		
Operating and Recovery Room		
Radiation Therapy and Chemotherapy		
Anesthesia and Inhalation Therapy		
Inpatient Surgeon's Charges	80%	60%
Second Surgical Opinion	80%	60%
Outpatient Facility Services includes:		
Operating Room, Recovery Room, Procedure Room and Treatment Room including:	80%	60%
Physician Services		
Diagnostic/Therapeutic Lab and X-rays		
Anesthesia and Inhalation Therapy		
Outpatient Preadmission Testing		
Office Visit	80%	60%
Outpatient Facility	80%	60%
Laboratory and Radiology Services such as:		
MRIs, MRAs, CAT Scans and PET Scans	80%	60%
Other Laboratory and Radiology Services	80%	60%
Short-Term Rehabilitative Therapy including Physical, Speech, Occupational and Chiropractic Therapies	80%	60%
Prescription Drugs		
For both Retail and Mail Order Drugs Combined:		
Annual Deductible (Separate from your medical deductible)	$25 per individual/$75 per family	
Plan Pays	90% for generic drugs, 80% for preferred brand drugs, and 60% for non-preferred brand drugs	Covered in-network only
Your 2014 Annual Maximum Copay, excluding deductible	$750 per person	
2014 Maximum Out-Of-Pocket expense per year	$775 per person ($750 maximum copays plus $25 annual deductible), and then the plan pays 100% for the rest of the calendar year.	
Emergency and Urgent Care Services		
Physician's Office	80%	If true emergency, benefits are the same as the in-network benefits. If not a true emergency, benefits are paid at 60%
Emergency Room, Urgent Care or Outpatient Facility	80%	
Ambulance	80%	
Maternity Care Services		
Initial Office Visit to Confirm Pregnancy	80%	60%
All other office visits	80%	60%
Delivery		
Hospital Charges	80%	60%
Physician Charges	80%	60%
Inpatient Services at Other Health Care Facilities		
Including Skilled Nursing, Rehabilitation and Sub-Acute Facilities	80% - 60 days maximum per calendar year* ***All inpatient hospital admissions required Precertification. Call the toll free number on your ID Card.***	60% - 60 days maximum per calendar year* ***All inpatient hospital admissions required Precertification. Call the toll free number on your ID Card.***

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Home Health Services	80%	60%
Family Planning Services		
Office Visits (tests, counseling)	80%	60%
X-ray/lab if billed by separate facility	80%	60%
Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	80%	60%
Outpatient Facility	80%	60%
Surgery in Physician's Office	80%	60%
Infertility Services (Up to $50,000 Lifetime Maximum)		
Office Visit (tests, counseling)	80%	60%
X-ray/lab if billed by separate facility	80%	60%
Treatment/Surgery (includes in-vitro fertilization, artificial insemination, GIFT and ZIFT.)		
Inpatient Facility/Physician's Charges	80%	60%
Outpatient Surgical Facility/Physician's Charges	80%	60%
In Physician's Office	80%	60%
Mental Health and Substance Abuse Precertification Required	**IN-NETWORK PARTICIPATING PROVIDER**	**OUT-OF-NETWORK NON-PARTICIPATING PROVIDER**
Inpatient Mental Health	100%	60%
Inpatient Substance Abuse	100%	60%
Inpatient Substance Abuse Detoxification	100%	60%
Inpatient Substance Abuse Rehab Facility	100%	60%
Outpatient Mental Health	100%	60%
Marital/Family Counseling	100%	Not Covered
Outpatient Substance Abuse	100%	60%
Durable Medical Equipment	80%	60%
External Prosthetic Equipment	80%	60%
Vision Care	$100 every two calendar years, no deductible or coinsurance, routine exams and lenses	
OTHER BENEFIT INFORMATION		
Annual Deductible		
Individual	$300	$500
Family	$600	$1,000
Annual Out-of-Pocket Maximum		
Individual	$2,000 plus deductible	$4,000 plus deductible
Family	$6,000 plus deductible	$12,000 plus deductible
Coinsurance	The plan pays 80% of eligible charges. You pay 20% of charges after the annual plan deductible.	The plan pays 60% of eligible charges. You pay 40% of charges after the annual plan deductible.
Precertification (Inpatient) for Hospital, Skilled Nursing, Rehabilitation and Sub-Acute Facilities.	Member must obtain approval	Member must obtain approval
Lifetime Maximum	Unlimited	Unlimited

Regarding In-Network and Out-of-Network services:

- Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year.
- All inpatient hospital admissions require Precertification and Continued Stay Review. Call the toll free number on your ID Card.

Regarding In-Network services: All services must be provided by preferred providers in order to be covered.

Regarding Out-of-Network services: Your out-of-pocket costs will be higher than with a preferred provider.